Guide to the Tuberculosis-Related Services Only Benefit

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Numbers

Wisconsin Medicaid' s Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility:

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient' s identification (ID) card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid Guide to the Tuberculosis-Related Services Only Benefit is issued to providers who provide services to recipients with tuberculosis. It contains information that applies to fee-for-service Medicaid providers.

Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid.

Medicaid recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements.

Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The Guide to the Tuberculosis-Related Services Only Benefit consists of the following chapters:

- General Information.
- Covered Services.
- Preparing Claims.

In addition to the Guide to the Tuberculosis-Related Services Only Benefit, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid

The following laws and regulations provide the legal framework for Wisconsin Medicaid:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and the *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations. Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and more information about Wisconsin Medicaid are available at Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS, to provide health claims processing, communications, and other related services.

General Information

Provider Information

Providers Currently Certified With Wisconsin Medicaid

Providers who are currently certified with Wisconsin Medicaid and wish to provide tuberculosis (TB)-related services to recipients of the TB-related services only benefit should follow the guidelines in this handbook. No separate certification is needed to provide TB-related services.

No separate certification is needed to provide TB-related services.

Refer to Appendix 1 of this handbook for a list of covered TB-related services and allowable providers that may be reimbursed for performing those services.

Providers Not Currently Certified With Wisconsin Medicaid

Providers are required to become certified with Wisconsin Medicaid to receive reimbursement for TB-related services.

Recipient Information

Recipients eligible for the TB-related services only benefit are eligible for Wisconsin Medicaid-covered outpatient services only. Wisconsin Medicaid does not reimburse any other services for these recipients. Recipients of the TB-related services only benefit receive a Wisconsin Medicaid *Forward* card and are identified by the medical status code "TR" through eligibility verification systems.

Wisconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the All-Provider Handbook for detailed information on accessing the EVS and eligibility for Wisconsin Medicaid. For telephone numbers regarding recipient eligibility, refer to the Important Telephone Numbers page at the beginning of this guide.

Tuberculosis-Related Services Only Recipient Eligibility Requirements

Tuberculosis Infection or Disease Criteria

For an individual being considered for TB-related services only eligibility, documentation of one of the following criteria is required, showing that the individual:

1. Has evidence of latent TB infection.
2. Has evidence of active TB disease.
3. Has a negative tuberculin skin test, but a positive sputum culture.
4. Tests negative for TB, but based on a physician's judgment, requires TB-related drug and/or surgical therapy.
5. Based on a physician's judgment, requires testing to confirm the presence (or absence) of the TB organism.

Individuals must also meet certain financial requirements. Providers should contact their county/tribal social or human services department, W-2 agency, or Medicaid outstation site for up-to-date financial requirements.

Some individuals may not be determined to be eligible for TB-related services until the infection is confirmed. These recipients may request that eligibility for the TB-related services only benefit be retroactive to the date the infection is confirmed.

Covered Services

Covered Tuberculosis-Related Services

The tuberculosis (TB)-related services only benefit is designed to cover outpatient TB-related services. This chapter includes information about services that are reimbursable when provided to recipients eligible for TB-related services only and the types of providers that may be reimbursed for providing the specific services.

Covered services must relate to the treatment or complications of TB and may vary depending on the individual's circumstances.

Covered services must relate to the treatment or complications of TB and may vary depending on the individual's circumstances. For example, services necessary because of side effects of drugs prescribed to treat TB may be covered as TB-related services.

Prescribed Drugs

Covered Services

Medicaid-covered TB-related drugs include, but are not limited to, the following:

- Capreomycin — Capastat®.
- Cycloserine — Seromycin®.
- Ethambutol — Myambutol®.
- Ethionamide — Trecator-SC®.
- Isoniazid.
- Kanamycin — Kantrex®.
- Pyrazinamide.
- Pyridoxine.
- P-aminosalicylic acid — PASER®.
- Rifabutin — Mycobutin®.
- Rifamate®.
- Rifampin — Rifadin®, Rimactane®.
- Rifater®.
- Streptomycin.

Pyridoxine tablets (Vitamin B_6 — 10, 25, 50, and 100 mg) are covered over-the-counter medications.

Wisconsin Medicaid covers other drugs that may be TB-related if the dispensing provider verifies this with the prescriber (e.g., a physician or nurse with prescribing authority).

Allowable Providers

Medicaid-certified pharmacists, physicians, and physician clinics may dispense drugs to recipients of the TB-related services only benefit.

Physician Services

Covered Services

Wisconsin Medicaid reimburses certified providers for physician and clinic services, including office visits relating to the TB diagnosis.

Allowable Providers

Medicaid-certified physicians, physician clinics, physician assistants, and nurse practitioners may provide physician and clinic services to recipients of the TB-related services only benefit within their scope of practice.

Laboratory Services

Covered Services

Wisconsin Medicaid reimburses certified providers for TB-related laboratory services. Covered laboratory services include services to diagnose and confirm the presence of TB infection.

Allowable Providers

Refer to Appendix 1 of this handbook for a list of providers who are eligible to provide TB-related laboratory services.

Radiology Services

Covered Services

Wisconsin Medicaid reimburses specific certified providers for TB-related radiology services. Covered radiology services include services to diagnose and confirm the presence of TB infection. Refer to Appendix 1 of this handbook for a complete list of covered radiology procedure codes.

Allowable Providers

Refer to Appendix 1 of this handbook for a list of providers eligible to provide TB-related radiology services.

Case Management Services

Covered Services

Case management services help a recipient and, when appropriate, the recipient's family gain access to, coordinate, or monitor necessary medical, social, educational, vocational, and other services.

All case management services are covered TB-related services. Refer to the Case Management Handbook for covered services and claims submission instructions.

Allowable Providers

Wisconsin Medicaid reimburses Wisconsin Medicaid-certified case management service providers for TB-related services.

Case management service providers must be Wisconsin Medicaid-certified for the target group "individuals infected with TB." The target group codes are:

- 44A-TB, non-COP.
- 44B-TB, COP.

Refer to the Case Management Handbook for the Case Management Target Population "Change Request" form.

Transportation Services

Covered Services

Recipients of the TB-related services only benefit are eligible for transportation to Medicaid-covered services. The recipient or the recipient's case manager must contact the county social services agency to arrange common carrier transportation.

Recipients who are ineligible to travel safely by common carrier transportation may be eligible for transportation by specialized medical vehicle (SMV). Tuberculosis infection alone is not sufficient for transportation by SMV.

Refer to the Specialized Medical Vehicle Services Handbook for information about SMV criteria.

Directly Observed Therapy and Directly Observed Preventive Therapy

Covered Services

Wisconsin Medicaid covers direct observation by a health care provider or other designated person as the recipient ingests TB medication.

Reimbursement rates for directly observed therapy (DOT) and directly observed preventive therapy (DOPT) include necessary travel time and delivery of medications (if free delivery is unavailable). Travel time and delivery of medications are not separately reimbursable.

Indicate the appropriate codes when submitting claims for DOT or DOPT, as follows:

- W6271: DOPT — TB infected only.
- W6274: DOT — suspect or confirmed active case.

Allowable Providers

Refer to Appendix 1 of this handbook for a list of providers who are eligible to provide TB-related DOT or DOPT services.

Recipients of the TB-related services only benefit are eligible for transportation to Medicaid-covered services.

Tuberculosis Symptom and Treatment Monitoring

Covered Services

Wisconsin Medicaid covers TB symptom and treatment monitoring, which includes:

- Clinical assessment of TB.
- Incorporating a history of treatment for TB infection or disease.
- Monitoring adherence to the prescribed regimen and signs and symptoms of disease.
- Adverse reactions.

Reimbursement rates for TB symptom and treatment monitoring include travel time. Therefore, travel time is not separately reimbursable. Indicate one of the following codes when submitting claims for these services:

- W6272: Symptom and treatment monitoring; TB infected only.
- W6275: Symptom and treatment monitoring; suspect or confirmed active case.

Allowable Providers

Refer to Appendix 1 of this handbook for a list of providers who are eligible to provide TB-related symptom and treatment monitoring services.

Patient Education and Anticipatory Guidance

Covered Services

Wisconsin Medicaid covers limited patient education and anticipatory guidance as TB-related services. Patient education and anticipatory guidance includes providing information about TB infection or disease, diagnostic tests, treatment, benefits of adherence to treatment, and follow-up care.

Reimbursement rates for patient education and anticipatory guidance include travel time. Therefore, travel time is not separately reimbursable. Indicate one of the following codes to bill for these services:

- W6273: Patient education and anticipatory guidance — TB infected only.
- W6276: Patient education and anticipatory guidance — suspect or confirmed active case.

Allowable Providers

Refer to Appendix 1 of this handbook for a list of providers who are eligible to provide TB-related patient education and anticipatory guidance services.

Services unrelated to the treatment or complications of TB are not covered under the TB-related services only benefit.

Noncovered Services

Inpatient Hospital and Nursing Home Services

Inpatient hospital services and nursing home services are not covered under the TB-related services only benefit. This benefit is designed to cover outpatient TB-related services only.

Services Unrelated to Tuberculosis

Services unrelated to the treatment or complications of TB are not covered under the TB-related services only benefit. For example, routine dental services and substance abuse day treatment services are not covered. Refer to HFS 107.03 and 107.06(5), Wis. Admin. Code, for further information about noncovered Medicaid services.

Preparing Claims

General Instructions

Providers should follow the claims submission instructions in their service-specific handbooks. For example, physicians should follow the instructions in the Physician Services Handbook and nurse practitioners should review the Nurse Practitioner Services Handbook.

When submitting claims on a monthly basis, providers should indicate the last date of service in the month only.

Diagnosis Codes

With the exception of independent laboratories, portable X-ray providers, and pharmacies, providers should indicate an *International Classification of Diseases, Ninth Revision, Clinical Modification* tuberculosis (TB) diagnosis code on the claim form when providing TB-related services. Refer to the list of TB-related diagnosis codes in Appendix 2 of this handbook.

Independent laboratories, portable X-ray providers, and pharmacies should refer to their service-specific handbooks for claims submission instructions relating to diagnosis codes.

Specific Service Instructions

When submitting a claim for directly observed therapy, TB symptom and treatment monitoring, or patient education and anticipatory guidance:

- Always indicate a TB diagnosis code as the first diagnosis on the claim form. Refer to the list of TB diagnosis codes in Appendix 2 of this handbook.
- Providers may find it easier to bill monthly. Accumulate the time spent providing services on a monthly basis and round to the nearest tenth of an hour (in minutes). When submitting claims on a monthly basis, providers should indicate the last date of service in the month only. Refer to Appendix 2 of this handbook for rounding guidelines.
- Do not charge a copayment. There are no copayments for these services.

Appendix

Appendix 1
Tuberculosis-Related Procedure Codes for All Recipients With Tuberculosis

The following chart shows tuberculosis (TB)-related Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, and *Current Procedural Terminology* (CPT) codes for the CMS 1500 claim form. The chart also shows the allowable place of service (POS) codes, type of service (TOS) codes, and an indication of whether or not Medicare covers the service. Check your service-specific handbook to verify other allowable procedures, along with their allowable POS and TOS codes.

Procedure Code		POS*	TOS**	Medicare Covered	Allowable Providers
HCPCS Codes					
W6271	Directly observed preventive therapy (DOPT) — TB-infected only	0, 2, 3, 4	1	No	• Federally qualified health centers. • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • Prenatal care coordination (PNCC) providers, including local health departments certified as PNCC providers. • Rural health clinics.
W6272	Tuberculosis symptom and treatment monitoring — TB-infected only	0, 2, 3, 4	1	No	• Federally qualified health centers. • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.
W6273	Patient education and anticipatory guidance — TB-infected only				

***POS codes are:**

0 Other
2 Outpatient hospital
3 Office
4 Home
A Independent Laboratory

****TOS codes are:**

1 Medical
4 Diagnostic X-ray (total charge)
5 Laboratory
Q Diagnostic X-ray (professional component only)

Appendix 1
(Continued)

Procedure Code		POS*	TOS**	Medicare Covered	Allowable Providers
HCPCS Codes (Continued)					
W6274	Directly observed therapy (DOT) — suspect or confirmed active case	0, 2, 3, 4	1	No	• Federally qualified health centers. • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.
W6275	Tuberculosis symptom and treatment monitoring — suspect or confirmed active case	0, 2, 3, 4	1	No	• Federally qualified health centers. • HealthCheck screeners. • Home health agencies. • Nurse midwives. • Nurse practitioners. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.
W6276	Patient education and anticipatory guidance — suspect or confirmed active case				
CPT Codes					
71010	Radiologic examination, chest; single view, frontal	0, 2, 3 (POS "2" not reimbursable with TOS "4")	4, Q	Yes	• Family planning clinics. • Federally qualified health centers. • HealthCheck screeners. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers.
71020	Radiologic examination, chest, two views, frontal and lateral				

***POS codes are:**

0 Other
2 Outpatient hospital
3 Office
4 Home
A Independent Laboratory

****TOS codes are:**

1 Medical
4 Diagnostic X-ray (total charge)
5 Laboratory
Q Diagnostic X-ray (professional component only)

Appendix

Appendix 1
(Continued)

Procedure Code		POS*	TOS**	Medicare Covered	Allowable Providers
CPT Codes (Continued)					
86580	Skin test; tuberculosis, intradermal	0, 3, A	5	Yes	• Family planning clinics. • Federally qualified health centers. • HealthCheck screeners. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.
89350	Sputum, obtaining specimen, aerosol induced technique (separate procedure)				
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	0, 2, 3	1	Yes	• Federally qualified health centers. • HealthCheck screeners. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	3	5	No	• Family planning clinics. • Federally qualified health centers. • HealthCheck screeners. • Independent laboratories. • Nurse midwives. • Nurse practitioners. • Outpatient hospitals. • Physician assistants. • Physician clinics. • Physicians. • PNCC providers, including local health departments certified as PNCC providers. • Rural health clinics.

***POS codes are:**

0 Other
2 Outpatient hospital
3 Office
4 Home
A Independent Laboratory

****TOS codes are:**

1 Medical
4 Diagnostic X-ray (total charge)
5 Laboratory
Q Diagnostic X-ray (professional component only)

Appendix 2
Tuberculosis-Related Diagnosis Codes and Rounding Guidelines

International Classification of Diseases, Ninth Revision, Clinical Modification **Diagnosis Codes**	
010.0x- 018.9x	Primary tuberculosis (TB) infection Pulmonary TB Other respiratory TB Tuberculosis of meninges and central nervous system Tuberculosis of intestines, peritoneum, and mesenteric glands Tuberculosis of bones and joints Tuberculosis of genitourinary system Tuberculosis of other organs Miliary TB
137.0- 137.4	Late effects of TB
771.2	Infections specific to the perinatal period; other congenital infections; congenital TB
795.5	Nonspecific abnormal histological and immunological findings; nonspecific reaction to tuberculin skin test without active TB
V01.1	Contact with or exposure to communicable diseases; TB
V12.01	Personal history of certain other diseases; infectious and parasitic diseases; TB
V71.2	Observation and evaluation for suspected conditions not found; observation for suspected TB
V72.5	Special investigations and examinations; radiological examination, not elsewhere classified
V74.1	Special screening examination for bacterial and spirochetal diseases; pulmonary TB

Rounding Guidelines	
Time (in minutes)	**Units Billed**
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

Crossover claim

A Medicare-allowed claim for a dual entitlee submitted to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual.

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

HCPCS

Health Care Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System

HealthCheck

A program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a given provider type and the maximum allowable fee and relative value units (RVUs) Wisconsin Medicaid assigns to each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin.Code, a service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Payee

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

POS

Place of service. A single-digit code which identifies the place where the service was performed.

QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

Qualifying circumstances

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

RVU

Relative value unit. A number assigned by Wisconsin Medicaid to indicate the relative clinical intensity and difficulty of the surgical, diagnostic, or therapeutic procedure code for which anesthesia services were performed. Relative value units are not necessarily equivalent to either federal or American Society of Anesthesiologists RVUs. Relative value units are indicated on the Physician Maximum Allowable Fee Schedule.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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